Jurisdictions

Partner

Finance

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Government

Chapter 4

Finance and governance: Principles and issues

The primary responsibility of state and local public health jurisdictions under the Public Health Improvement Plan is to meet the capacity standards, which represent the actions necessary to protect, promote, and improve health. While local structures vary, the responsibility to meet the capacity standards would be uniformly applied across the state.

Significant deficiencies in meeting the capacity standards exist at both the state and local levels. Public health, as currently organized and financed across the state, is inadequately prepared to meet the challenges of the future. The 1994 PHIP addresses the deficiencies with recommendations for increased resources, and by recommending changes in how local and state public health jurisdictions govern themselves, organize with other agencies and organizations, and work together.

There is a need to clarify the relationships between the many entities which share responsibility for public health. Local governments determine the structure of their local public health jurisdictions, resulting in varied organizational structures which, at times, impede coordinated and collaborative approaches across jurisdictions. Mutual accountability between local public health jurisdictions and the state must be established if Washington is to create a well-functioning statewide public health system. Interagency agreements are needed between the multiple federal, state and community agencies which have responsibilities and/or resources for meeting the capacity standards. The public health needs of Indians in Washington present some unique coordination issues between the tribes, the Indian Health Service, and state and local public health jurisdictions.

The resource base for the public health system is not adequate to fully meet the capacity standards. There is a lack of both state and local funds specifically dedicated to public health. The methods for distributing the funds do not encourage system-wide effectiveness and efficiency.

This chapter presents background on key public health finance and governance issues and recommendations to resolve these crucial issues.

Governing the public health system

Local public health jurisdictions

Title 70 RCW places primary responsibility for public health activities with local governments, giving them broad responsibilities for protecting the public health through program design and delivery, rule making authority and enforcement

Finance and governance principles

- The finance and governance structure must provide for stable, equitable revenue sources.
- The public health system must provide local governments with the flexibility and responsibility to determine local governance structures that are capable of fulfilling public health responsibilities.
- The finance and governance structure must include proportionate financing responsibilities among state and local governments for those public health functions that must be universally and equitably available statewide.
- The public health system serves the public at large as well as individuals, and the financing structure must reflect that balance.
- The finance and governance structure of the public health system must hold all publicly funded agencies and organizations accountable for the allocation and use of resources.
- The finance and governance structure of the public health system must balance diverse local needs, the resources necessary to address them and the ability to direct resources to accomplish the greatest good.
- In attempting to serve the greatest good, the public health system must give serious consideration to the potential for harm to any portion of the community.
- The finance and governance structure of the public health system must link the responsibility for financing with the authority for decision making.
- The public health system must integrate different perspectives of the community.

powers. Every city, town and county must either form a local health department (or district) or be part of a health department with other local jurisdictions (chapter 70.05 RCW).

Local governments are empowered to choose from four types of local health departments: single city, town or county department; combined city/county department; single county health district; or multi-county health district.[1]

Each city, town, and county is financially responsible for the cost of public health activities in its respective jurisdiction. The board of health for each jurisdiction determines the portion of financial responsibility of each local government. RCW 70.05.145 establishes an arbitration procedure for resolving disputes that may arise between local governments and the public health jurisdiction.

The 1993 Health Services Act amends the local public health statutes in several ways. The act decreases the variation in local public health structures and creates dedicated local funding. Specifically the act:

1. *Removes cities and towns from the definitions of local health departments, local board of health, and health district;*

2. *Removes cities and towns from local boards of health and from health districts;*

3. *Repeals the requirement that cities and towns form separate health departments, join a health district or purchase health services from other health departments;*

4. *Gives county boards of health jurisdiction over cities and towns within the county boundaries;*

5. *Repeals the statute that allowed single counties to form health districts;*

6. *Removes the financial responsibility of cities and towns for public health and repeals the arbitration language, placing the full financial responsibility for public health on each county in the state; and*

7. *Establishes a dedicated financing structure by allocating 2.95% of the Motor Vehicle Excise Tax (MVET) to county health departments exclusively for the purpose of public health. (This portion of the MVET is currently part of the 8.83% of allocated to cities and towns for police and fire protection and preservation of public health.)*

These changes have an effective date of July 1, 1995. The Health Services Act requested the governing authorities of the Association of Washington Cities, the Washington State Association of Counties, and the Washington Association of County Officials (the "Tri-Association") to jointly study and develop consensus recommendations regarding the implementation of these amendments. The act also required that the study and the PHIP be coordinated. The Washington State Association of Local Public Health Officials and the State Department of Health have participated in the study as advisors.

Finance and governance principles (continued)

- The finance and governance structure of the public health system must recognize diverse perspectives and encourage community ownership through participation in determining and meeting state and local priorities.
- The finance and governance structure of the public health system must support the performance of the core public health functions of assessment, policy development and assurance.
- The finance and governance structure of the public health system must foster long term prevention.
- The finance and governance structure of the public health system must promote decision making which balances data, scientific information, available resources, and community priorities.
- The public health system must encourage partnerships with other agencies, tribal governments, and organizations which affect delivery of public health and related services in the communities. The Public Health Improvement Plan Steering Committee identified a number of issues that will be considered in the next PHIP. Those issues are described under the “Agenda for the Future” section of this plan.

Local boards of health: As described above, the governing boards of existing local public health jurisdictions include county elected officials, and, in the case of districts, representatives from city governments. Effective July 1, 1995, the Health Services Act limits representation on local boards of health to county elected officials.

The capacity standards require community involvement in public health core functions. Since the authority for designating public health governance resides at the local level, expanding board of health membership to include non-elected community representatives is one possible way that local public health jurisdictions could involve the community. The current laws have been interpreted to preclude non-elected citizens, so some amendment of the law is needed to give jurisdictions the option of including non-elected citizens.

Collaboration between local jurisdictions and with others: When resources are limited, health care providers and health-related agencies must join forces to fully meet the health needs of a community. Collaboration is a critical strategy for efficient use of limited resources. Local public health jurisdictions must often work with communities, cities, counties, tribal governments and the Indian Health Service, each with their own priorities and responsibilities. Also, the capacity to promote and protect health — as well as the magnitude of public health problems — varies considerably from community to community, so the sharing of resources and expertise can be a cost-effective way to enhance capacity in all areas of the state.

The necessary collaboration among local public health jurisdictions and other community organizations may not happen automatically. Since new state funds should be tied to enhancing core function capacity, the mechanisms for distributing these funds should include financial incentives that promote partnerships. The governance recommendations provide incentives to local public health jurisdictions that plan to meet the capacity standards through collaboration.

Authority of the State Secretary of Health

At the state level, development of public health policy resides with the Secretary of Health and the State Board of Health. The Secretary is appointed by the Governor and heads the State Department of Health. Under RCW 43.70.130, the Secretary has broad powers to investigate health threats, enforce public health laws, and generally supervise the official public health system for the purpose of establishing uniform reporting. Although local health officers have primary responsibility for preserving the public health within their jurisdictions, the Secretary is empowered to intervene when the local jurisdiction either cannot or will not enforce public health laws. The Secretary may also intervene when an emergency threatening the safety of the public exists beyond the capability of the local jurisdiction. The Secretary can also gain authority in a local health jurisdiction through an agreement with the local health officer or the local board of health. The finance and governance recommendations do not alter the responsibilities and authority of the Secretary of Health.

Authority of the State Board of Health

Through the Washington Health Services Act, the Legislature reaffirmed the basic mandate of the State Board of Health contained in Article XX of the Washington State Constitution of 1889. The board "provides a forum for the development of public health policy in Washington State," and has rulemaking authority to protect

Local health boards set policy

Local boards of health are responsible for approving the use of all funds coming into their department or district. The board has discretionary powers for how local funds are applied to meet the particular needs of the community. Other funds, such as from state and federal sources, are often designated for a particular program, and must be formally accepted by the boards before any services can start. If public health needs are identified that require immediate attention and are not part of the annual budget, the board has the authority to shift funds or request additional help from local or state governments.

Local boards of health usually hold monthly public meetings. In most cases their deliberations are met with little public comment and scant attention from the media, but there have been some exceptions. In 1989, the Tacoma-Pierce County Board of Health meetings had standing-room-only and national media attention as the board approved public funding for the nation's first needle exchange program.

public health, improve the health status of Washington residents, and "promote and assess the quality, cost, and accessibility of health care throughout the state," as stipulated in RCW 43.20.050 and RCW 43.70.050.

The State Board of Health is an independent citizen board composed of ten members appointed by the Governor broadly representative of consumers, persons experienced in matters of health and sanitation, elected officials, and local health officers. It is "empowered to hold hearings and explore ways to improve the health status of the citizenry."

Chapter 5 of this report describes future study needed regarding the State Board of Health and State Department of Health responsibilities and activities that may overlap. This analysis will be completed as part of the next PHIP.

Tribal governments

As United States citizens and residents of Washington State, American Indians are eligible to participate in federal and state health programs, including state public health programs. Since 1955, they have also been eligible for services provided by the federal Indian Health Service (IHS), which is the payer of last resort. Most Indians receive their health care through IHS or IHS contract care facilities.

IHS is funded by Congress to support only 60% of the tribes' medical needs, resulting in a lack of adequate facilities and a limit on the tribes' ability to develop effective preventive programs. Many basic public health services, such as food programs, are not funded. The Department of Health and local public health jurisdictions have the technical expertise to help tribal governments develop needed public health services. No additional financing for developing capacity exists on reservations, but some arrangements with IHS may be possible in the future as tribes move toward self determination through federal Public Law 93-638 contracting or self governance. The federal Self-Determination Act of 1975 allows the U.S. Secretary of the Interior and the U.S. Secretary of Health and Human Services to contract directly with tribal governments to administer Bureau of Indian Affairs or Indian Health Service programs. These contracts enable tribal governments to manage their own housing, law enforcement, education, health, social service, and community development programs or to subcontract with other entities.

The state Interlocal Cooperation Act (chapter 39.34 RCW) is the means for tribes and local government to work together in establishing formal agreements. Possibly the greatest barrier to such health-related agreements is the issue of enforcement authority held by public health officials, especially concerning environmental health matters. State or local government attempts to impose authority will not succeed. Tribes should be approached with an invitation to participate and with a clear recognition by state and local authorities of tribal sovereignty.

This plan provides an opportunity for local and tribal governments to work together to enhance public health activities so that American Indians have public health protection and services consistent with the capacity standards. Therefore, local health jurisdictions should go beyond simply extending an invitation to tribes to participate in the planning process. They should take the initiative to learn tribal protocols, offering information and technical support to develop core public health capacity on the reservation.

Indian Health Service relationships with tribes in Washington State

There are 26 federally recognized tribes in Washington State, occupying reservations which vary greatly in terms of geography, resources and population. In order to make health services accessible, the tribes and the Indian Health Services (IHS) have adopted a variety of service approaches. IHS provides services four different ways in this state:

(1) Tribes assuming self governance, through a compact with the federal government, receive funds to provide health care and public health services based on a plan developed by tribal government (e.g., the Lummi Tribe);

(2) Tribes contract with IHS for funds to provide all federally-mandated services under IHS; these services are delivered by the tribe strictly as outlined by IHS (e.g., the Puyallup Tribe);

(3) Tribes contract with IHS for funds to provide public health services, while IHS provides outpatient and direct medical care, including contract health care (e.g., the Colville Tribe);

(4) Small tribes without their own IHS clinic receive vouchers for members to obtain contract services at a nearby private clinic or at the nearest IHS facility. Small tribes may, in some cases, depend on local public health jurisdictions for some clinical preventive care (e.g., the Kalispel Tribe).

These relationships would primarily be between local public health jurisdictions and tribes, based on the framework for government-to-government cooperation and implementing procedures included in the Centennial Accord of 1989 (see Appendix C). The Department of Health should play an active role in bringing together local and tribal governments, and provide technical assistance to tribes that choose to develop core public health function capacity.

Financing the public health system

A strong infrastructure at both the state and local government levels is fundamental to meeting capacity standards. This infrastructure must be built on a solid fiscal foundation with three elements: (a) adequate levels of funds; (b) dedicated sources of financing; and (c) methods of distributing funds that encourage system-wide effectiveness and efficiency.

Adequate financing for public health

Almost half of the current funding for public health is from local resources, about twenty five percent is from state resources, and about twenty eight percent is from federal and other resources. The total amount spent for public health varies greatly among the 33 jurisdictions, from a high of nearly $60 per resident per year to less that $15 per resident per year. This disparity occurs because of decisions made by local governments regarding type and scope of programs, potential for additional funds, and population size.

Adequate financing to meet the capacity standards is the first element of a solid public health infrastructure. The funding level must be responsive to population growth, changing health status, and community priorities. In addition, public health funds should be linked to the expenditures of the overall health system, as public health becomes a more integral and vital component of that system.

Dedicated sources of financing

Sources of public health financing include categorical and grant funds, as well as fees and permit revenues. Categorical funds, those designated for a specific program or to solve a specific problem, are usually neither flexible nor stable. Because categorical funds are usually inflexible, duplication and inefficient use of resources can occur between programs that have overlapping functions or needs.

Virtually no state and local government financing sources are dedicated exclusively for public health on a permanent basis. Currently, local government contributions are used as a match for grant programs and Medicaid billing, to support the administrative costs of categorical programs, to subsidize clinical services or to substantially underwrite the costs of other services (for example, environmental health services through fee support and local contributions). The result is a system that is neither flexible nor stable, and lacks the ability to provide the additional resources necessary to meet capacity standards.

Dedicated sources of financing are necessary to support the ongoing development of the public health system in order for the system to be built and maintained on a stable funding base. A dedicated funding source, such as a portion of a state or local tax dedicated on an ongoing basis for public health purposes, would add stability to the funding base of public health. As stated previously above, the 1993 Health Services

What is public health infrastructure?

An effective public health system has an infrastructure that is just as important — but not as obvious — as the transportation infrastructure. In the transportation system we need sufficient, stable financing to pay for roads, rails, ports, and airports that have adequate capacity and are of high quality. This is essential for moving commercial goods to market and for moving people to work, services, homes, schools, and recreation.

Likewise, we need sufficient, stable financing to pay for the "roads and rails" of public health — the data and monitoring systems, the technical expertise to investigate disease outbreaks, the personnel to inspect restaurants and septic systems, the community knowledge to bring groups and resources together to prevent threats to health. Without adequate infrastructure, communities will not have the information or resources necessary to solve today's health problems or avoid those that will threaten us in the future.

Act, effective July 1, 1995, transfers 2.95% of the Motor Vehicle Excise Tax (MVET) to county health departments and districts to provide public health services; and makes counties solely responsible for local public health financing.

While the MVET could serve as one source of dedicated financing for local public health jurisdictions, it alone is insufficient to allow public health to meet the capacity standards. In fact, in some cases it reduces the amount of local (city or county) funding obligations to public health while in other cases it increases those obligations.[2] While the state is exploring ways to lessen the impact of the gains and losses due to MVET, other dedicated sources of funding must be identified that are stable and reliable.

State-level dedicated financing is needed. The Health Services Act states that the Health Services Account was created to include expenditures for maintaining and expanding health services access for low income residents, maintaining and expanding the public health system, containing health care costs, and the regulation, planning, and administering of the health care system. Therefore, a portion of the Health Services Account is an appropriate dedicated funding source for implementation of the PHIP. In addition to MVET as a dedicated source for local jurisdictions, and the Health Services Account as a dedicated source for state funding, other dedicated sources are necessary for the financing of the PHIP.

Financing distribution methods

The public health system requires financing distribution methods which move the state and local public health jurisdictions towards increased effectiveness and efficiency, and through which federal, state and local governments share equitably in the financing. Local government ability to pay for public health, as well as local population characteristics and geography, need to be considered in determining these shares. Incentives will be designed to promote collaborations between government agencies and between the private and voluntary sectors. The incentives should support the implementation strategies directed toward achieving full capacity by 2001. Further system accountability should be achieved through performance-based contracts tied to attaining capacity standards.

The 1993 Legislature allocated $10 million in funds for the 1993-95 biennium directly to local health jurisdictions on a per capita basis. These funds were to be used for "urgent public health needs" that jurisdictions could determine based on community priorities and needs. The positive experience of this fund allocation method suggests that a system which assures flexibility in priority-setting at the local level, with accountability for meeting those priorities, can be very successful in meeting public health needs in local communities, leveraging local and other resources, and encouraging partnerships. (See Appendix D for a discussion of the use of Urgent Public Health Needs funds).

Regionalization works

In 1992, the Washington Department of Health Public Health Laboratories and the Spokane County Health District formed an interagency work group to evaluate the state's public health laboratories. The group recommended the formation of a state/local regional laboratory system. Spokane County Health District became the first regional site laboratory and serves 13 eastern Washington counties. This consolidation resulted in lower test costs, faster turn around time, and more services available to a larger number of clients. This initiative on the part of state and local public health in understanding the needs of their customers and communities fostered a strong sense of partnership and improved public health in that region.

Finance and governance recommendations

Responsibilities and relationships of state and local public health jurisdictions

1. *Local public health jurisdictions, including tribal governments, are responsible for promoting and protecting the health of their communities. The state may play a consultative or prescriptive role with local jurisdictions, depending on their performance. Specifically,:*

   a. *The Department of Health and local public health jurisdictions should jointly establish clear measures of whether local public health jurisdictions are meeting the capacity standards.*

   b. *State financing of local public health jurisdictions should be linked to specific agreements (e.g. contracts) for meeting capacity standards. (The state will encourage jurisdictions to collaborate with other entities in order to meet the capacity standards.)*

   c. *The achievement of capacity standards should become the basis for the Department of Health evaluation of local public health jurisdictions' performance. The Department of Health and local public health jurisdictions' objectives and budgets should reflect the priorities of the PHIP.*

2. *The Department of Health, in consultation with the State Board of Health and local health jurisdictions, has ultimate responsibility and authority to assure compliance with capacity standards. The Department of Health, in consultation with the State Board of Health and local public health jurisdictions, will have overall responsibility and authority for development, implementation, and evaluation of the PHIP.*

3. *The Department of Health and local public health jurisdictions should jointly develop an evaluation tool to allow local public health jurisdictions to categorize themselves according to their ability and desire to meet capacity standards. The categories will guide financing strategies and incentives for collaboration and regionalization. The recommended categories are as follows:*

   Category A

   Jurisdictions that declare independent ability to meet the capacity standards as defined in the PHIP or have strategies currently in place to accomplish same within a defined period of time.

   Example: A large local public health jurisdiction that has established capacity in all core function areas declares its intention to independently achieve capacity standards by the year 2001. With additional state funds for the PHIP, and redirecting all local government contributions to include those previously used for clinical services (which are transitioning to the uniform benefits package), this local public health jurisdiction will progress incrementally toward full achievement of the capacity standards.

Category B

Jurisdictions that declare some independent ability to meet capacity standards and have strategies in place to increase capacity through collaboration with other entities (such as other local public health jurisdictions, community providers, Department of Health, etc.), within a defined period of time.

Example: A medium-sized local public health jurisdiction, surrounded by other medium-sized or small local public health jurisdictions, elects to combine resources with one or more local public health jurisdictions to achieve greater efficiency in meeting assessment, administration, and health promotion capacity standards. The local public health jurisdiction has strategies in place, however, to independently meet capacity standards for health protection, policy development and access/quality assurance. Or two or three adjacent local public health jurisdictions combine resources to meet capacity standards in order to achieve a greater economy of scale. Or any combination of the above. These local public health jurisdictions may also contract with other public or private entities, such as hospitals or universities, to assist with specific activities related to the capacity standards.

Category C

Jurisdictions that declare no independent ability to meet capacity standards and do not have strategies in place to increase capacity. These jurisdictions must develop an agreement to contract with the Department of Health to meet the capacity standards.

Example: A small local public health jurisdiction recognizes the lack of available local resources to independently meet the capacity standards and chooses not to make the fundamental changes required to meet the standards. Political barriers may also inhibit collaboration with other local public health jurisdictions. In this case, the small local public health jurisdiction would declare its desire to have the Department of Health determine and carry out strategies to meet the capacity standards. The Department of Health would then charge the local government for the cost of implementing those strategies.

4. *If a local public health jurisdiction does not fulfill its responsibilities as defined by the capacity standards, the state must, as a last resort, exercise its ultimate authority for public health, and will assume responsibility and charge the local government(s) as appropriate.*

Relationships of state and local boards of health

5. *The RCWs should be amended to allow for a minority of non-elected citizen participation on local boards of health.*

Relationships of Indian tribes and public health jurisdictions

6. *Local public health jurisdictions and the Department of Health must recognize the autonomy of tribal government. Tribes have the independent authority to determine their own capacity standards; set urgent public health priorities; and carry out core public health functions.*

Building capacity statewide

One strategy to target state funds to promote the PHIP implementation could occur through the recommended process of local public health jurisdiction self-categorization. By using the evaluation tool jointly developed by the Department of Health and local public health departments, a local public health jurisdiction would assess its current ability and desire to meet capacity standards. A local public health jurisdiction would declare to Department of Health its strategy by selecting a category designation (categories A, B, or C) for meeting each capacity standard grouping. In addition, the local public health jurisdiction would indicate its local priorities for funds, to be considered, along with the recommended emphases for new state funds, in negotiating the performance based contracts. These contracts would be specific to the individual capacity standards, and funds would be targeted for those capacity standards.

For example, if a large local public health jurisdiction with a desire to independently meet all capacity standards has a relative weakness in assessment and policy development functions, the contract for new state funds could target development in those areas. If the local public health jurisdiction has relative strength in health protection capacity, no new funds would be targeted for those capacity standards.

7. *The State Legislature should fully fund Section 469 of the Health Services Act of 1993, the American Indian health care delivery plan, and designate the Department of Health as the lead agency to work in partnership with the tribes to coordinate, develop, and implement the plan with the other appropriate state agencies. The plan must include: (1) recommendations to providers and facilities on methods for coordinating and joint venturing with the Indian Health Service and the tribes for service delivery; (2) methods to improve American Indian-specific health programming; and (3) creation of co-funding recommendations and opportunities for the unmet services programming needs of American Indians.*

8. *The Department of Health should assume a lead role in promoting cooperation between local public health jurisdictions and tribes, including agreements for supporting development of capacity functions and responses to public health emergencies. The primary relationships should be between local public health jurisdictions and tribes, based on the framework for government-to-government cooperation and implementing procedures included in the Centennial Accord of 1989.*

9. *Local health jurisdictions have an obligation to recognize tribal governments within their boundaries equal to the recognition and privileges accorded other local units of government. This should include, but not be limited to, representation and inclusion in community health assessment, planning, and core function capacity development.*

State and local public health jurisdiction financing

10. *Total public health financing should equal $83 per capita in 1994 dollars, or approximately 2.3% of total annual health system expenditures.*

11. *Multiple sources of dedicated funds for public health should include a percentage of the Health Services Account, a mechanism whereby private sector financing of health care reflects the public costs of protection and promotion of the health of the population, and other sources as identified in the future.*

12. *New state funds for public health should be deposited in the Public Health Services Account.*

13. *Dedicated funds should be used to finance the core function capacity, urgent public health needs, and emergency public health needs.*

14. *New 1995-97 state dedicated funds for enhancing local capacity, and shared state and local capacity, should emphasize, but not be used exclusively for, the core capacity functions of assessment, health promotion, and access/quality assurance.*

15. *The state/local government shares of financing core function capacity should be approximately equal statewide by 2001.*

Inter-governmental collaboration in northeastern Washington

The Kalispel Reservation is located within Pend Oreille County. It is beautiful but sparsely populated country, with the Pend Oreille River flowing north from Idaho into Canada, surrounded by the Selkirk Mountains. The Reservation is 25 miles from the nearest medical services and over eighty miles away from the Indian Health Service (IHS) Unit that is responsible for providing health care to tribal members. Since 1989, through a contract with IHS, the Northeast Tri-County Health District has provided services to the Kalispel including home visits for prenatal and postnatal education and support services; immunizations for all ages, including flu shots for the elders in their homes; follow up with social workers and day care workers on family issues; and health education. The key to this successful relationship is the understanding on the part of the District that the needs of the reservation must be met within the context of the culture of the Kalispel people. Frequent communication occurs between the public health nurse, the community health representative, and the tribal elders. This complementary relationship results in improved health status for not only the Reservation, but also for the District as a whole.

16. *The Department of Health should be responsible for distributing state funds for public health, consistent with the following provisions:*

    a. *Additional state funds for public health should be used solely to expand and complement, but not supplant, local government support for public health programs. The local government tax revenue used to support public health will be based on calendar year 1993 or an alternative calendar year as arrived at through negotiations with the Department of Health.*

    b. *Local public health jurisdictions that cannot meet the capacity standards alone but that have strategies or a plan to collaborate with other local public health jurisdictions or other organizations in order to meet the standards, will receive an increased match rate during a transition period. That is, local public health jurisdictions in Category B will receive, as a short-term incentive, funding to offset the costs of collaboration.*

    c. *The state's method(s) of distributing funds to local public health jurisdictions should consider the local government's ability to pay, population, geography, and other characteristics. Ability to pay should be determined by a formula that considers assessed property values, population, and other relevant factors.*

Based on these finance and governance recommendations, the 88 capacity standards in Chapter 3, and the vision of the public health system in Chapter 2, an implementation plan has been developed. The implementation plan is the topic of the next chapter.

1. Title 70 RCW places primary responsibility for public health activities with local governments, giving them broad responsibilities for protecting the public health through program design and delivery, rule making authority and enforcement powers. Every city, town and county must either form a local health department or be part of a health department with other local jurisdictions (chapter 70.005 RCW).

Local governments are empowered to choose from among the following types of local health departments:

- Single city, town or county department (RCW 70.05.020 and RCW 70.05.030)

  The board of health has the same membership as the governing body of the city, town or county. The jurisdiction of the board of health coexists with the boundary of the city, town or county, with the exception that county boards of health do not have jurisdiction over the cities with populations over 100,000 or over cities or towns that are providing or purchasing public health services. (There are currently no single city or town health departments in Washington State).

- Combined city/county department (chapter 70.08 RCW)

  Cities with a population of over 100,000 may combine with their county to form a health department. The governing bodies of the city and county establish and operate a combined city/county department and appoint a director of public health. The statute does not mention the composition of the board of health.

- Single county health district (RCW 70.46.030)

  The membership of the board is defined in statute, and must represent the county, cities and towns that comprise the district. The governing bodies of the cities and towns must mutually agree on the members that will represent them on the board. The members must be from the governing bodies of the county, cities and towns (except in counties with a population between 70,000 and 125,000, the board shall include a "qualified voter of an unincorporated rural area of the county"). The jurisdiction of the district is the county and all cities and towns within its boundaries (cities with populations over 100,000 have an option of whether to join the district). If a city of over 100,000 population is included in a single county district, the city shall have representation on the board equal to the county commissioners. City board members are appointed from the membership of their governing body.

- Multi-county health district (RCW 70.46.020)

  The membership of the board is defined in statute, and must represent the counties, cities and towns that comprise the district. The members must be from the governing bodies of the counties, cities and towns. The governing bodies of the cities and towns must mutually agree on the members that will represent them on the board. The jurisdiction of the district is the county and all cities and towns within its boundaries (cities with populations over 100,000 have an option of whether to join the district).

2. Analysis by the Association of Washington Cities, 1994